Arizona State Senate
Issue Brief

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Note to Reader:

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DISPROPORTIONATE SHARE HOSPITAL PAYMENT PROGRAM

INTRODUCTION

The Medicaid Disproportionate Share Hospital (DSH) Payments Program was established by Congress in the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981) to support hospitals that serve large numbers of Medicaid and low-income patients. Hospitals with a high proportion of Medicaid patients often also have many uninsured patients and low numbers of privately insured individuals, and therefore may be limited in their ability to shift the costs of uncompensated care to the privately insured. OBRA 1981 also changed how Medicaid payments to hospitals were calculated and Congress was concerned that the change might harm hospitals that served large numbers of Medicaid patients. As a result, the legislation required states to "take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs" when determining payment rates for inpatient hospital care.

FEDERAL REQUIREMENTS

Under the DSH program, a state makes a separate payment to a hospital in addition to its standard Medicaid reimbursement. After the state makes the DSH payment, the federal government reimburses the state for part of the cost of the payment, based on the state's Medicaid matching rate.

Federal law allows a hospital to be considered a DSH hospital if the hospital has a Medicaid inpatient utilization rate (the share of total inpatient days attributable to Medicaid patients) of at least one percent and has at least two obstetricians with staff privileges who agree to serve Medicaid patients (excluding children's hospitals). In addition, the hospital must serve a specified proportion of Medicaid or low-income patients. Within federal guidelines, states have flexibility in the structure of their DSH programs and states may include additional hospitals in their definition of an eligible hospital as long as the criteria is more generous than the minimum federal standards.

Over time, Congress has enacted adjustments to the DSH program, including restricting the types of fund sources states can use as the state's share of DSH payments, setting state-specific allotments of federal DSH funding, capping total DSH payments at 12 percent of total Medicaid benefits payments and establishing a formula to determine the maximum DSH funding each hospital may receive.[1] States are then free to determine how to direct their funding to hospitals as long as the methodology does not violate federal requirements.

ARIZONA'S DSH PROGRAM

Administered by the Arizona Health Care Cost Containment System (AHCCCS), Arizona's DSH program was first established by the Legislature in 1991. In Arizona, there are four groups eligible for DSH payments. Neither state statute nor AHCCCS rule specifies the eligibility criteria; rather, the qualifications are enumerated in AHCCCS policy. The first two groups are based on the federal requirements; the last two are state options that include county, state and private hospitals:

- hospitals whose Medicaid inpatient utilization rate is at least one standard deviation above the state's mean Medicaid inpatient utilization rate.
- hospitals with a low-income utilization rate of more than 25 percent.
- acute care general hospitals that have either a low-income utilization rate greater than the statewide average or provide at least 1 percent of total Medicaid days in the state.
- State, county and certain special health care district hospitals (currently, the Arizona State Hospital and the Maricopa Medical Center).

Each year, the Legislature appropriates the total funds available for DSH payments (federal Title XIX Medicaid funds and state General Fund monies) to AHCCCS. A footnote in the General Appropriation Act then distributes the total amount from AHCCCS to qualifying private hospitals, the Maricopa County Special Health Care District Hospital and the Arizona State Hospital. The Special Health Care District retains a small portion of the payments for uncompensated care and transfers the remainder to Maricopa County. One of the annual budget reconciliation bills requires the remainder amount to be withheld from the county's transaction privilege tax (TPT or sales tax) revenue distribution. In the case of the Arizona State Hospital, the funding essentially passes through and reverts back to the state General Fund.

DSH FUNDING FLOW CHART

The flow chart on the following page demonstrates how DSH funding flows from the state through the Maricopa County Special Health Care District and the Arizona State Hospital and results in a net gain to the state General Fund.

ADDITIONAL RESOURCES

- Title XIX of the Social Security Act, Sections 1092 and 1923 (42 U.S.C. 1396a and 42 U.S.C.1396r-4)
- Title 36, Chapter 29, Arizona Revised Statutes (A.R.S. § 36-2903.01)
- "*Deconstructing DSH: An Arizona Policy Primer*," Linda Cannon, St. Luke's Health Initiatives, July 2003
- "*Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payment*s," Robert E. Mechanic, National Health Policy Forum, The George Washington University, September 2004

[1] In the early 1990s, many states began using fund sources such as provider taxes, donations and intergovernmental transfers to finance the state's share of DSH payments without having to use actual state dollars. In addition, states were making payments to certain facilities in excess of the facilities' uncompensated care burden in order to funnel the monies back through the state. Many congressional changes to the DSH program have limited the states' abilities to use these creative financing mechanisms. The federal government has deemed Arizona's DSH financing acceptable.

- *"The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues,"* Teresa A. Coughlin and David Liska, The Urban Institute, October 1997
- Annual Appropriations Report, Joint Legislative Budget Committee www.azleg.gov/jlbc.htm

DSH FUNDING FLOW CHART